Metropolitan Life Insurance Company

MetLife

Statement of Claim for
Accidental Dismemberment Benefits and Additional Benefits

TO THE EMPLOYER/RECORDKEEPER

WHEN THIS FORM SHOULD BE COMPLETED

You should **always** complete this form when the insured or covered dependent suffers an accidental injury that results in a covered loss other than death. Completion of a separate life insurance claim form is not necessary.

Please note that this form may include benefits that are not part of your plan; MetLife will review the claim in accordance with your specific plan provisions.

INSTRUCTIONS FOR COMPLETION

1. Complete **Part A (Employer's Statement)** on page 2 and provide the entire form to the claimant.
2. Instruct the claimant to complete **Part B (Claimant's Statement)**, and submit the entire form **(Parts A and B)**, plus any additional documents and forms, such as **Part C (Attending Physician Statement)** to MetLife.
3. Contact the MetLife Administrator responsible for your group if you have further questions.

TO THE CLAIMANT

To ensure that you have knowledge of all of the benefits that are included in the Group Accidental Dismemberment (AD&D) plan, this claim form is being provided to you.

The employer has completed **Part A, the Employer's Statement**. The Description of Benefits below provides a list of benefits that may be available under AD&D plans ; however please be aware that your particular plan may not include all of these benefits. Please refer to your group certificate or Summary Plan Description for specific plan details.

To file a claim for AD&D benefits, complete **Part B, the Claimant's Statement**. Your claim may also require that your physician complete an **Attending Physician's Statement (Part C)**.

Upon completion, send all parts of the form to MetLife:

MetLife
Group Life Claims
P.O. Box 6100
Scranton, PA 18505
1-800-638-6420

Upon receipt, your claim will be thoroughly reviewed. It may be necessary for MetLife to request additional information before a final determination is made.

DESCRIPTION OF BENEFITS

If the insured suffers an accident and meets the conditions for any of the benefits listed below, and if that benefit is included in the employer's plan, an accidental dismemberment benefit or additional amount may be payable.

Refer to your group certificate or Summary Plan Description for a complete description of these benefits. Not all plans include these benefits.

- **Permanent and Irreversible Brain Damage**
- **Third Degree Burn**
- **Coma**
- **Unavoidable Exposure to the Elements**
- **Limb/Digit Amputation**
- **Entire and Irrevocable Loss of Hearing in Both Ears**
- **Entire and Irrevocable Loss of Speech**
- **Permanent and Uncorrectable Loss of Vision in One or Both Eyes**
- **Complete, Permanent and Irreversible Paralysis**
- **Rehabilitative Physical Therapy**

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Part A - Employer's Statement (To be Completed by the Employer) (Please Answer All Questions)

Name of Insured Employee (First, Middle, Last)	Employee Social Security Number	☐ Male ☐ Female

Date of Birth	Date of Accident	Date of Loss (if applicable)

Date of Hire	Basic Annual Earnings $	as of Date

Employee is: ☐ Hourly or ☐ Salaried ☐ Union or ☐ Non-Union ☐ Exempt or ☐ Non-Exempt

Was Insurance ever assigned? ☐ Yes ☐ No
(If yes, please attach a copy of assignment and all related papers)

Employee's full amount of VAD&D Insurance $_____ Report #_____ Sub _____ Branch _____

Employee's full amount of AD&D Insurance $_____ Report #_____ Sub _____ Branch _____

Employee's full amount of OAD&D Insurance $_____ Report #_____ Sub _____ Branch _____

Employee's full amount of DAD&D Insurance $_____ Report #_____ Sub _____ Branch _____

☐ Active Employee	Effective date of amount claimed	☐ Retired Employee	Date Retired

If the employee was not actively at work at date of death or loss, please indicate status (Choose one):

☐ Regular Retiree ☐ Retired Due to Disability ☐ Terminated Due to Disability
☐ Terminated for any Other Reason ☐ Leave of Absence/Layoff/Sick Leave ☐ Disabled (Not terminated or retired)

Date Last Worked	Reason for Stopping

Date Premium Payments for Employee Stopped	Was Life Insurance Cancelled? ☐ Yes ☐ No	Date

Was the Employer/Employee relationship terminated before the death or loss? ☐ Yes ☐ No	Date	Reason

Was a Total and Permanent Disability or Continued Protection (CP) disability waiver claim ever filed with MetLife for this employee? ☐ Yes ☐ No	Disability Case Number

Dependent Claim Only

Date of Loss (if applicable)	Date of Birth	Dependent Social Security Number

Relationship (Spouse/Child)	Name of Dependent (First, Middle, Last)	☐ Male ☐ Female

Address

Employer Name _____ Phone No. _____ (Area Code)

Address _____

Date Signed _____ Print Name _____

Signature of Employer Representative _____

FRAUD WARNINGS

Before signing this claim form, please read the warning for the state where you reside and for the state where the insurance policy under which you are claiming a benefit was issued.

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

Arizona: For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas, District of Columbia, Louisiana, Minnesota, New Mexico, Ohio, Rhode Island and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California: For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Delaware, Idaho, Indiana and Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Florida: A person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maine, Tennessee, Virginia and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud as provided in R.S.A. 638.20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

Oregon: Any person who knowingly presents a false statement of claim for insurance may be guilty of a criminal offense and subject to penalties under state law.

Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Texas: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Vermont: Fraudulent insurance act. No person shall, with intent to defraud: present or cause to be presented a claim for payment or benefit, pursuant to any insurance policy, that contains false representations as to any material fact or which conceals a material fact; or present or cause to be presented any information which contains false representations as to any material fact or which conceals a material fact concerning the solicitation for sale of any insurance policy or purported insurance policy, an application for certificate of authority, or the financial condition of any insurer.

Pennsylvania and all other states: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any material fact thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

MetLife

Part B - Claimant's Statement (To be Completed by the Claimant)

Information about the Insured Employee: (It is not necessary to complete this section if you are the claimant as well as the insured)

1. Insured Employee Name (First, Middle, Last)	2. Employer Name
3. Address	
4. Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced	

Information about you:

1. Your Name (First, Middle, Last)		2. Social Security Number
3. Date of Birth	4. Phone Number Day:	Evening:
5. Address		
6. Fax Number (Optional)		
7. Relationship to the Insured: ☐ Spouse ☐ Child ☐ Parent ☐ Self ☐ Other (explain)		
8. When did the accident happen? Date (Month) (Date) (Year) at (Hour) { a.m. / p.m.		
9. Where did the accident happen?	City	State

10. Give a brief description of the accident _____

_____

_____

_____

Certifications and Signature:

By signing below, I acknowledge:

1. All information I have given is true and complete to the best of my knowledge and belief.
2. I consent to the pro rata deduction of any contributions owed by the insured from insurance proceeds paid to me.
3. I have read the applicable Fraud Warning(s) provided in this form.

Under penalty of perjury, I certify:

1. **That the number shown on this form is my correct taxpayer identification number; and**
2. **That I am not subject to IRS required backup withholding as a result of failure to report all interest or dividend income; and**
3. **I am a U.S. citizen, or a U.S. resident for tax purposes.**

(Please note: You must cross out item 2 and/or item 3 above if the IRS has notified you that you are currently subject to backup withholding because you failed to report all interest and dividend income on your tax return; or you are not a U.S. citizen or U.S. resident for tax purposes.)

The IRS does not require your consent to any provision of this document other than the certification to avoid backup withholding.

Please sign below (include first and last name). If Beneficiary is a minor, the legal guardian or adult submitting this form must sign, not the minor. If no legal guardian is appointed to handle the minor's estate, a responsible adult should complete and sign the claimant statement on behalf of the minor beneficiary. If a legal guardian of the minor child's estate has been or will be appointed, the guardian must complete and sign the claimant statement. Be sure to include a copy of the court-issued guardianship papers in the claim submission to MetLife.

_____ _____

Claimant Signature Date Signed

Name of Insured Employee _____ Insured's Employer's Name _____

Part C - Attending Physician's Statement

1. Name of patient (First, Middle, Last)	Age	2. Date of accident causing present loss (Month, Day, Year)
3. Date first consulted on account of the injury described (Month, Day, Year)		4. Date of last treatment for this condition (Month, Day, Year)

5. Describe the exact nature, location, and extent of all injuries sustained _____

6. Was the injury described solely responsible for the loss? ☐ Yes ☐ No
If not, give the particular of any contributing cause or causes. _____

7. Names of any other physicians who treated the patient for a contributory condition and the dates of their first and last treatments as reported to you. _____

8. In your opinion, was the loss caused in any way by illness? ☐ Yes ☐ No
If yes, what was the date you provided treatment for the illness? _____

9. Did the patient ever consult you before? ☐ Yes ☐ No
If yes, please state the dates and the ailments for which you attended, treated, or examined. _____

Please also complete the applicable section for the benefit being claimed.

To be Completed Only For Limb/Digit Amputations

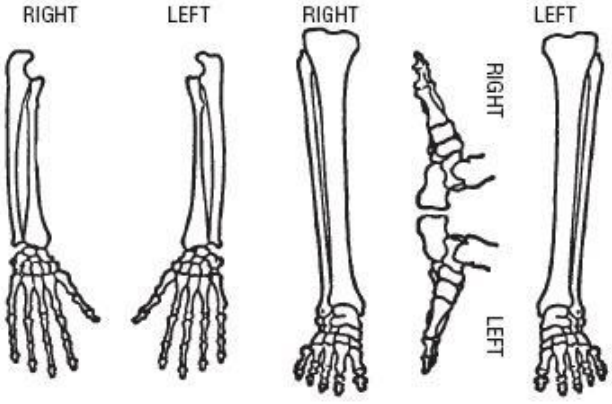
What limb/digit was severed or amputated?

State the dates on which the severance or amputation occurred.

State the cause of the amputation.

If the limb/digit was reattached, indicate date of reattachment and functional outcome.

State the exact point at which the amputation was performed or the severance occurred with respect to each limb/digit lost. If the severance or amputation was below the elbow or knee joint, indicate on the chart the exact point of severance.



Signature of Attending Physician _____ Date Signed (Month, Day, Year) _____

Print Name of Attending Physician _____ Name of Facility _____

Address _____ ( ) – Phone Number _____

Name of Insured Employee _____ Insured's Employer's Name _____

To be Completed Only For Loss of Vision

Has the patient had entire and irrecoverable loss of sight following the injury?

☐ Yes ☐ No

If yes, please answer the following:

Give the date you first determined vision was irrecoverably reduced to 20/200 (Snellen Notation) or less with correction and the vision then remaining in each eye.

Date _____

	Uncorrected	Corrected
O.D.v.		
O.S.v.		

(Snellen Notations)

Give the date and vision found on last eye examination.

Date _____

	Uncorrected	Corrected
O.D.v.		
O.S.v.		

(Snellen Notations)

State the cause of loss of vision:

_____

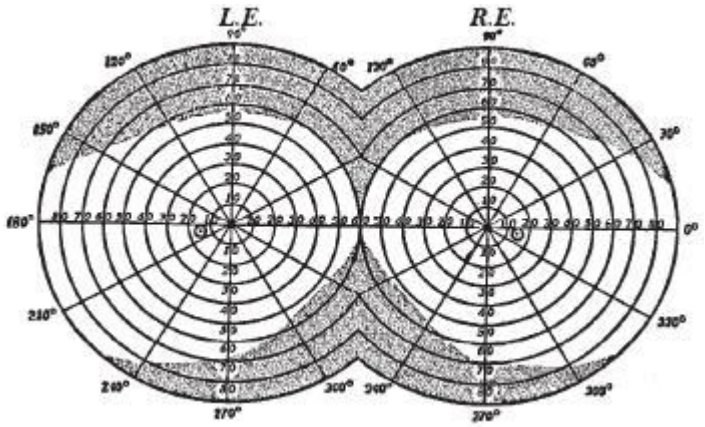
_____

_____

Indicate whether recovery or useful vision is possible by operation or treatment.

O.D.	☐ Operation	☐ Treatment
O.S.	☐ Operation	☐ Treatment

If fields of vision are contracted, show contraction on chart below.



To be Completed Only For Burn

Has the patient suffered third degree burns as a result of an accident? ☐ Yes ☐ No

What percentage of the body surface suffered third degree burns?

_____%

Location of third degree burns.

_____

_____

_____

_____

To be Completed Only For Rehabilitative Physical Therapy

Did the patient suffer a loss resulting from an accidental injury? ☐ Yes ☐ No

Date of accidental injury: _____

Did you prescribe rehabilitative physical therapy for the patient as a consequence of the loss? ☐ Yes ☐ No

Date therapy prescribed: _____

_____ _____

Signature of Attending Physician | Date Signed (Month, Day, Year)

_____ _____

Print Name of Attending Physician | Name of Facility

_____ (____) ____–_____

Address | Phone Number

Name of Insured Employee _____ Insured's Employer's Name _____

To be Completed Only For Paralysis

Date you first determined paralysis was permanent, complete and irreversible, etiology of the paralysis, and method of correction and result.

a) Date _____

b) Etiology _____

Specific limb(s) paralyzed _____

Location of lesion(s) responsible _____

Type of lesion(s) responsible _____

Test results which document paralysis (i.e., physical exam, EMG, nerve conduction tests) _____

Method of correction

Functional result of correction _____

To be Completed Only For Loss of Speech

State duration in months of patient's entire and irrecoverable loss of speech following the injury. _____

Date you first determined speech was irrecoverably lost and the specific etiology for absence of speech (vocalization) and method and results of correction.

a) Date _____

b) Specify basis for speech loss:

	Description Uncorrected	Corrected Method
Absence of vocalization structure(s)		
Evidence of obstruction		
Evidence of air passage defect		

To be Completed Only For Loss of Hearing

State duration, in months, of patient's entire and irrecoverable loss of hearing following the injury? _____

Date you first determined hearing was irrecoverably lost and the residual hearing (dB) uncorrected and corrected as tested by audiometer in a soundproof room.

a) Date _____

b) Audiometry:

	Left Ear Uncorrected / Corrected	Right Ear Uncorrected / Corrected
500 Hz	/	/
1,000 Hz	/	/
2,000 Hz	/	/
3,000 Hz	/	/

Date the test results which allowed you to determine the hearing loss lasted consecutively for the duration indicated above.

a) Date _____

b) Audiometry:

	Left Ear Uncorrected / Corrected	Right Ear Uncorrected / Corrected
500 Hz	/	/
1,000 Hz	/	/
2,000 Hz	/	/
3,000 Hz	/	/

_____ _____

Signature of Attending Physician | Date Signed (Month, Day, Year)

_____ _____

Print Name of Attending Physician | Name of Facility

_____ ( ) –

Address | Phone Number

Name of Insured Employee _____ Insured's Employer's Name _____

To be Completed Only For Brain Damage	To be Completed Only For Coma
Has the patient suffered permanent and irreversible physical damage to the brain as a result of an accidental injury, causing the complete inability to perform all the substantial and material functions and activities normal to everyday life? ☐ Yes ☐ No Date of accidental injury: _____ Date brain damage manifested itself: _____ Was the patient hospitalized as a result of the accidental injury? ☐ Yes ☐ No Dates of hospitalization: _____ _____ State duration, in months, brain damage persisted after the injury? _____ _____	Did the patient enter into a state of deep and total unconsciousness from which he/she cannot be aroused as a result of an accidental injury? ☐ Yes ☐ No Date of accidental injury: _____ Date coma began: _____ Is the patient still in a coma? ☐ Yes ☐ No If the patient is not in a coma now, date coma ended: _____

To Be Completed Only For Exposure

Was the patient involved in an accident that resulted in loss of life or limb due to unavoidable exposure to the elements?
☐ Yes ☐ No

If loss of life, please explain how the exposure resulted in death.

_____
_____
_____

If loss of limb, which limbs were lost?

_____
_____
_____

State the dates on which amputations occurred.

_____
_____
_____

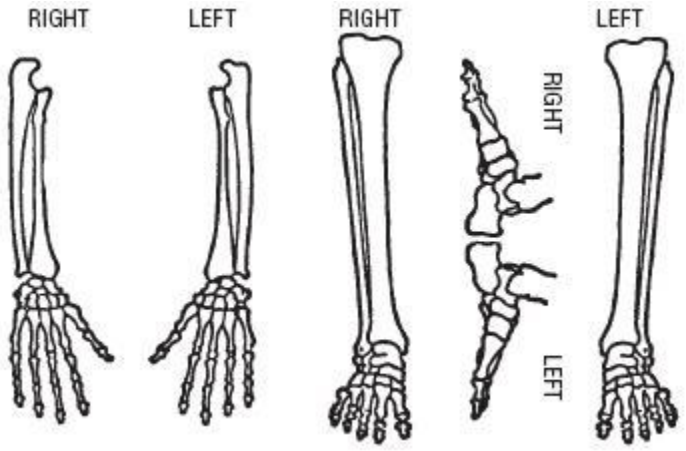
State the cause of the amputation.

_____
_____
_____

If the limb was reattached, indicate date of reattachment and functional outcome.

_____
_____

State the exact point at which the amputation was performed with respect to each limb lost. If the amputation was below the elbow or knee indicate on the chart the exact point of severance. _____
_____
_____
_____



_____ _____
Signature of Attending Physician Date Signed (Month, Day, Year)

_____ _____
Print Name of Attending Physician Name of Facility

_____ ( ) –
Address Phone Number